PRESCRIPTION DRUG CLAIM FORM

DIRECT POLICYHOLDER REIMBURSEMENT

Mail this form along with receipts to:
HIRSP – Navitus™ Health Solutions
P.O. Box 999
Appleton, WI 54912-0999

Use this form for prescriptions that were purchased without using your ID card or after you have submitted your claim to a primary insurance carrier. If you are submitting a Coordination of Benefits claim and you do not have a copy of the Explanation of Benefits or denial from your Primary Insurance Company, please contact your pharmacy for the print out to be attached to this claim form. Compound drugs must be submitted using the Compound Drug Claim Form. NOTE: You will be reimbursed directly for covered services up to the HIRSP contracted amount. Reimbursement will be made directly to the Policyholder unless otherwise noted.

Policyholder Name:	**Policyholder #:**		
Policyholder Address:	**City:**	**State:**	**Zip:**
Group #:	**Group Name:**		
Policyholder's Gender: __ Female __ Male	**Policyholder Date of Birth:**		
Does Policyholder have other drug coverage: __Yes __No **If yes, complete the information in the boxes below and attach a copy of the Explanation of Benefits (EOB) or Denial notification from the Primary Insurance Carrier.**			

PRESCRIPTION INFORMATION:
THIS SECTION MUST BE COMPLETED BY YOU OR YOUR DISPENSING PHARMACIST. PRESCRIPTION RECEIPTS OR PRINTOUTS MUST BE ATTACHED. RECEIPTS CANNOT BE RETURNED; PLEASE KEEP A COPY IF NEEDED.

 # 1
Pharmacy Name_____ **Address**_____

Rx Number_____ **Drug Name & Strength**_____ **NDC #**_____

Original Date of Rx _____ **Date Filled**_____ **Quantity**_____ **Days Supply** _____

Physician Name _____ **Physician DEA #**_____

Other Insurance Company Name _____ **Other Insurance Phone Number** _____

Original Cost of Rx $_____ **Amount Primary Insurance Paid on Rx $**_____ **Policyholder Paid Amount $**_____

 # 2
Pharmacy Name_____ **Address**_____

Rx Number_____ **Drug Name & Strength**_____ **NDC #**_____

Original Date of Rx _____ **Date Filled**_____ **Quantity**_____ **Days Supply** _____

Physician Name _____ **Physician DEA #**_____

Other Insurance Company Name _____ **Other Insurance Phone Number** _____

Original Cost of Rx $_____ **Amount Primary Insurance Paid on Rx $**_____ **Policyholder Paid Amount $**_____

PLEASE SIGN AND DATE HERE: I CERTIFY THE ABOVE INFORMATION IS CORRECT, AND THE PRESCRIPTIONS LISTED ABOVE ARE FOR MYSELF AND I HAVE RECEIVED THE MEDICATION DESCRIBED ABOVE, AND AUTHORIZE RELEASE OF ALL INFORMATION CONTAINED ON THIS CLAIM TO NAVITUS AND MY PLAN SPONSOR.

SIGNATURE: _____ DATE SIGNED: _____

YOUR CLAIM CANNOT BE PROCESSED UNLESS THIS FORM IS COMPLETE.

INCOMPLETE FORMS WILL BE RETURNED FOR ADDITIONAL INFORMATION WITHOUT PAYMENT.